MINNEAPOLIS DEPARTMENT OF HEALTH AND FAMILY SUPPORT

SUMMARY OF THE COMMUNITY HEALTH SERVICES NEEDS ASSESSMENT AND PLAN FOR 2000-2003

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I. EXECUTIVE SUMMARY

A: Introduction

The Minnesota Community Health Services (CHS) Act of 1976 (later renamed the Local Public Health Act) established a public health infrastructure based on a state and local partnership. The Act allowed the state to provide funds to local governments to assess community health needs, as well as plan and deliver services to address those needs. The Act requires local Community Health Services Boards to prepare and submit CHS plans to the State Commissioner of Health every four years. Community Health Services are defined as services that protect and improve people's health by preventing illness, disease, and disability.

The Local Public Health Act allows counties and certain cities, including Minneapolis, to: organize a Board of Health to exercise authority under the Act; receive CHS subsidy funds from the State; and, provide community health services. The City Council of Minneapolis acts as the Minneapolis CHS Board of Health. The completed Minneapolis plan is combined with those of Richfield, Edina, Bloomington, and the Hennepin County Community Health Department plan to form the Hennepin County CHS plan. This joint plan is sent to the Minnesota Department of Health, and Community Health Services funds are awarded to counties based on a statewide allocation formula. Minneapolis receives a direct share of the Hennepin County subsidy based on an allocation formula.

B: The Community Health Services Plan Approval Process

In the early 1990's the Minneapolis Health Department was renamed to be the Minneapolis Department of Health and Family Support (MDHFS). This was done to reflect the desire of the City to have a single department that focuses on the "human infrastructure" of the City, including the health and social concerns that affect the well being of Minneapolis families and communities. The MDHFS provides services under the direction of the Commissioner of Health and Family Support, who is accountable to the Mayor and City Council/Board of Health. Every four years MDHFS undergoes a planning process for the CHS plan. The planning process has evolved over time to reflect the changes in how the Department does business. The plan is developed with community input and with the on-going review and support of the City's Public Health Advisory Committee.

According to the Local Public Health Act:

> *The city councils or county boards that have established or are members of a community health board must appoint a community health advisory committee to advise, consult with, and make recommendations to the community health board on matters pertaining to the development, maintenance, funding, and evaluation of community health services. The committee must consist of at least five members and must be generally representative of the population and health care providers of the community health services area.*

The Public Health Advisory Committee provides input into the programs of the MDHFS, and has representation from each of the 13 Minneapolis wards, citizens, and health and human service agencies. The CHS Plan is developed with input from this Committee, and the Committee approved the Plan on June 15, 1999. The

MDHFS then sponsored two public hearings at two community park locations. A total of 16 people came to the hearings and provided input to and clarifications of the plan. This is the best attendance ever at a Minneapolis CHS public hearing. The plan was then referred to the Health and Human Services Committee, which is a standing committee of the City Council that focuses on the health, safety, and social well-being of the citizens of Minneapolis. The City Council gives final approval to the plan in their capacity as the Board of Health for the City of Minneapolis.

Once the plan is approved by the City Council, it is referred to the Hennepin County Community Health Department, which presents all the CHS plans in Hennepin County to the Hennepin County Commissioners for approval in September, 1999. All the CHS plans in Hennepin County will go as a package to the Minnesota Department of Health by October 31, 1999.

C: CHS Assessment and Plan

The CHS plan is composed of two main sections, the needs assessment and the program plan.

1. CHS Needs Assessment

The CHS needs assessment provides comprehensive data on the health status and needs of the citizens of Minneapolis. In the complete CHS Needs Assessment and Plan, the data is presented for Minneapolis and compared to other geographical area, including Hennepin County, Bloomington, Richfield, Edina, and /or suburban Hennepin County. Also, the MDHFS has the organizational capacity to do ongoing research of health problems with input from community stakeholders. The local Minneapolis needs assessment process is described in more detail this plan summary.

2. CHS Program Plan

The CHS Program Plan section identifies the processes used to determine the priority health problems for Minneapolis. Using both the assessment data, and an extensive prioritization process that involved the PHAC and staff, three major program areas emerged as priorities for MDHFS. These major projects involve:

1. Researching and determining action strategies needed for Minneapolis individuals and families to attain stability and self-sufficiency.
2. Developing a better framework for policies and services affecting the health and welfare of new arrivals to Minneapolis.
3. Develop more effective public health strategies for addressing domestic violence.

Other significant initiatives include health care access, chemical abuse and prevention, seniors, housing, asthma, children's health issues, and contract management.

There are also ongoing activities of the Department that require significant resources and reflect important ongoing commitments to improve the health of Minneapolis citizens. These programs include the School Based Clinics, violence prevention,

immunizations, ongoing assessment and policy initiatives, and American Indian, housing, and senior advocacy.

The CHS Program Plan is formatted using five populations and/or program categories. The categories emerged as the logical way for Minneapolis to organize the plan so it reflected local health and social needs. The five organizing categories for the plan are:

1. Family planning, prenatal care, birth outcomes, and children 0-5 years old
2. School age children and youth
3. Community health
4. Social health, disparities, and access
5. Institutional relationships

Each category includes:

1. Minneapolis problems that apply to that category
2. Appropriate Healthy Minnesotan 2004 Goals
3. Appropriate Healthy Minnesotan 2004 Objectives
4. Program objectives and methods for major initiatives
5. Ongoing activities are summarized
6. Current contracts, grants, and administrative agreements
7. Community resources
8. MDH technical assistance needed, and
9. MDHFS contact for further information

In the CHS Program Plan, an evaluation plan is presented for the entire CHS Program Plan: 2000-2003, as well as a summary evaluation for the CHS Plan: 1996-1999.

D: The Future

Through the CHS Needs Assessment and Plan, the MDHFS seeks to address underlying social and health problems that affect the well-being of the residents of Minneapolis. The priorities and programs identified in the CHS plan will direct the work of the Department in solving these problems, in partnership with community stakeholders. The Department has written the "MDHFS Guide to Planning Stakeholder Involvement," (included in Appendix B of the CHS Needs Assessment), which is used by the Department for determining the most effective strategies for involving community members in public health issues. In addition, if anyone reading this document would like to work on a health issue, please call Becky McIntosh at (612) 673-2884 or the Department contacts throughout the plan.

Together, we can improve the health of the citizen's of Minneapolis.

PUBLIC HEALTH AGENCY & CITY FACT SHEET

For more information, contact:
Becky McIntosh
Phone: (612) 673-2884

Community health board name:
City Council of Minneapolis
Structure/type of membership:
Member counties:

INFORMATION BY CITY

Name of city:
Minneapolis

Name of public health department:
Minneapolis Department of Health & Family Support

Address: 250 S 4th Street, Room 510
Minneapolis, MN 55415-1372
Phone: (612) 673-2301
FAX: (612) 673-3866
e-mail: health.familysupport@ci.minneapolis.mn.us

PUBLIC HEALTH STAFF

Number of FTE: (includes contracts)
…professionals 135
…paraprofessionals 36

1999 Total budget for CHS: $11,964,623

% CHS subsidy: 15% 1,781,216)

% from city tax levy: 42% (5,038,475)
General Funds

GEOGRAPHY

Total square miles: 58.7

Name of largest town/city:
N/A

Population of the largest town/city: N/A

UNIQUE FEATURES

CITY POPULATION

Estimated population: (1997 Estimate) 362,090
(1990 Census) 368,383

All below info from 1990 Census

Percent children (ages 0-19) 23.5%
Percent elderly (65+) 13%

Rate: White 78.5% American Indian 3.3%
Black 13% Asian/Pacific Islander 4.3%

Ethnicity: Hispanic 2%
Not Hispanic 88%

People of all ages in poverty: 18.5%
Persons under age 18 in poverty: 30%
Related children ages 5-17 in families In poverty: 33.3%
Total school enrollment: (1997-98 Public Schools) 49,364
Number of school districts: 1 - MPS
Number of schools: (1997) 95 - Public
College enrollment: (1997) 62,513*

HEALTH CARE

Number of hospitals: 6
Number of licensed hospital beds: 3,749
Number of nursing homes: 34
Number of primary care physicians: N/A
Number of dentists: N/A

Travel time/distance and/or availability of care is an Issue in this city for:
Primary care
Acute care
Dental care

*This does not include professional schools. It does include U of M Minneapolis/St. Paul and Metropolitan State University Minneapolis/St. Paul campuses.

III. EVALUATION OF PREVIOUS CHS PLAN: 1996-1999

Introduction

When the CHS Update was done for 1998-1999, the reorganization of the Minneapolis Department of Health and Family Support (MDHFS) was described. This reorganization resulted in three major changes:

1. The Department stopped providing most direct services, except for the Public Health Laboratory and the School Based Clinic Program. All other services were transferred to other organizations, provided through contracts, or discontinued.
2. The Department functions were organized around the three core functions of public health - research (assessment), policy, and assurance.
3. The Department merged with the City Department of Neighborhood Services, which included the Minneapolis Employment and Training Program (METP). This merger brought many programs to the public health table, including METP initiatives, which provides assistance to disadvantaged adults and youths to help them enter private sector employment. They also work with welfare-to-work programs. In addition all of the City's advocacy services, housing, seniors, and Native American advocacy, were integrated into MDHFS.

The successes and challenges experienced by the Department are directly related to these major changes.

Successes

The major success has been the completed reorganization of MDHFS around the three core functions. The organization has structured the work of staff and managers around these three areas. The intent was to encourage research, policy/advocacy, and assurance to influence each other in a cyclical manner. This has begun to occur as research/assessment activities have directed policy initiatives, which are then reflected in contracts and in the evaluation of services (which circles back to assessment). An example of this process is the youth violence prevention program that started with research on youth homicides, moved into community forums that resulted in policy directions and action plans, contracts for services for the "Stay Alive" project, and evaluation of the "Stay Alive" project by the research staff. Results of the evaluation will be used for not only program planning purposes, but will be considered in future research decisions and in making any changes in policy directions around youth violence.

Another major success of the reorganization has been the significant expansion of the department's assessment and research capacity. This has provided on-going assessment activities at a level beyond the capacity of almost any other CHS agency in the state, as detailed in the CHS Assessment.

Other accomplishments include:

1. Established the Stay Alive program in 1998 (as part of the Youth Violence Program), to serve primarily African American and American Indian males ages 17-25 living in the Phillips, Powderhorn, and Near North communities, with past criminal histories. The project served 198 youth in 1998, and 268 in 1999. The young men were offered positive activities, connected with positive adult males, offered culturally appropriate mentorship and direction, and assisted with career education and employment opportunities. A detailed evaluation has been done that will help direct the program in the future, as well as help determine if "Stay Alive" should be expanded to serve males in the Asian and Latino communities.
2. Provided medical care, counseling, nutrition, and health education to 2135 Minneapolis students through school-based clinics and education programs.
3. Collaborated with the Minneapolis Public Schools resulting in a major reorganization of school health services, an initial pilot program completed for collecting health status data for Minneapolis school children, and the founding of the Healthy Learners Board. The Healthy Learners Board is a collaboration of school, public, and private partners working toward improving the health of Minneapolis students. The first project of Healthy Learners Board was the "No Shots, No School" campaign to get all students fully immunized for the fall of 1999. The campaign had a 98% success rate.
4. Managed 150 contracts that provided over $10 million in health and human services in Minneapolis.
5. Completed and disseminated the results from the Survey of the Health of Adults, the Population, and the Environment (SHAPE).

Challenges

One challenge of reorganizing around the three core functions has been linking all three functions together in a systematic way. MDHFS has made good progress in linking research findings to policy initiatives. However, it's a challenge to link policy to assurance and to have assurance functions influence what research activities are carried out. For example, it has proven difficult to evaluate MDHFS' many contracts to assure services are meeting needs identified through policy and research activities. Efforts are continuing to refine this process.

A second major challenge is the need to continue to improve community partnerships, as the needs identified by research and policy initiatives far exceed MDHFS' capacity to address on its own. Since MDHFS no longer implements new health initiatives through direct service programs, we must work closely with community partners to meet emerging public health needs.

A third major challenge is the continued integration of the components of the department – public health, employment and training, and human services – towards the purpose of reducing barriers and using non-traditional channels to meet the multiple needs of Minneapolis residents. Transitions in leadership stalled the process for 1998, but significant planning steps have been taken in 1999 as detailed in the CHS Plan.

IV. Minneapolis Community Needs Assessment Process and Community Participation

As reported in the CHS Plan Update for 1998-1999, the MDHFS reorganized around the three core public health functions, research (assessment), policy, and assurance. The reorganization and creation of an expanded dedicated research unit has allowed more focused research to be done on key Minneapolis public health problems and opportunities. By hiring additional trained staff, the MDHFS has been able to conduct significant ongoing assessment and research.

In addition, MDHFS cooperated with Hennepin County Community Health Department (HCCHD) and Bloomington, Richfield, and Edina (BER) to complete a major compilation of county-wide health data. This data was organized according to Minnesota 2004 Goals and Objectives. When data was available, comparisons were made for Hennepin County, Minneapolis, BER, and /or suburban Hennepin County. Existing data sources were used, including vital statistics, Survey of the Health of Adults, the Population, and the Environment (SHAPE), and the Minnesota Student Survey.

This means Minneapolis data in this CHS assessment is based on joint data sources used by all the Hennepin County CHS agencies, as well as current MDHFS reports and published data. MDHFS has published numerous reports on major health issues in Minneapolis, including birth outcomes, STDs, senior health, State of the City, and SHAPE study findings. This assessment does not address all twelve public health problem areas, but rather reports in more depth on the problems and opportunities that MDHFS, in cooperation with other CHS agencies, has researched in the last few years.

Given MDHFS' ongoing assessment capability, it is able to respond to the need for data for important and emerging public health problems. The goals of the Minneapolis assessment process are: 1) widely disseminate the results of research findings; 2) write the reports in easy-to-understand English so stakeholders can understand and act on findings; and 3) use research to develop policy directions and actions plans for MDHFS and other community stakeholders.

The assessment function is interconnected with the other two MDHFS functions of policy and assurance. When an important area for research is identified, the results of that research are communicated to policy and assurance staff. The research findings deeply influence the activities of these two functions in terms of program directions and priorities.

MDHFS is keenly aware of and committed to community stakeholder involvement in discussing the City's public health problems and opportunities. Research is not a separate endeavor, but involves stakeholders at nearly every step of a research project.

Different projects and reports have involved community members in many different ways that are detailed in each published report. Community participation has included:

1) Planning/steering committees to determine how research will be conducted.
2) Developing research instruments and helping recruit participants.
3) Carrying out research by participating in focus groups, doing compliance checks, filling out surveys, and being interviewed.
4) Participating on task forces to analyze report findings and develop community action
5) Planning community forums to distribute and discuss report findings, as well as plan future action steps.

Because the MDHFS provides no direct services, other than the School Based Clinics program and the Public Health Laboratory, MDHFS sees its research, policy, and assurance functions with its accompanying stakeholder involvement as a catalyst for effective change in the community.

One of the MDHFS' major collaborators is the Hennepin County Community Health Department (HCCHD), which also has a separate assessment unit. The two agencies' most extensive collaboration has been with the SHAPE project (the Survey of the Health of Adults, the Population, and the Environment).

The CHS Needs Assessment: 2000-2003 lists the research reports published by MDHFS, some in cooperation with other organizations. Instead of writing a community description, we have enclosed the State of the City, 1998. This report provides a comprehensive look at the economic, social, health, and physical environments in the City of Minneapolis. Stakeholder involvement varied with each project depending on the unique nature of the project. Each report outlines in detail the specific stakeholder involvement. Below, stakeholder involvement will be described for three reports to give a flavor of the different processes used.

Survey of the Health of Adults, the Population, and the Environment (SHAPE)

SHAPE was one of the biggest undertakings of MDHFS, and was done in cooperation with HCCHD with additional help from the University of Minnesota. A survey was given to 10,000 Minneapolis and suburban Hennepin County residents. As a result, SHAPE data provides, for the first time, Minneapolis community-level information on chronic disease, injury, and behavioral risks. SHAPE data integrates this information with data on perceptions of community, personal safety, and discrimination, as well as demographic factors such as income, employment, and race/ethnicity.

The SHAPE survey was designed to provide local governments, community agencies, and policymakers with Countywide, City, and community-level health status information for the first time. In addition, SHAPE was designed in such a way that the survey could be repeated in order to track changes over time among the county population as a whole, and within geographic and population groups.

Through collaboration of MDHFS and HCCHD, the effectiveness of both departments' community health assessment activities was maximized and a more complete health status analysis of Minneapolis and county residents was developed. The survey data and analysis resulting from this collaboration will enable local health departments to plan activities and policy initiatives more effectively, to respond more quickly and effectively to the data needs of community groups who provide health services to county residents, and to enhance community-wide policies and interventions.

SEXUALLY TRANSMITTED DISEASES

In 1996, research staff noted the very high rates of STDs in Minneapolis compared to Minnesota and the USA. Elected officials also became aware of this information, and Mayor Sharon Sayles Belton asked the MDHFS to conduct more intensive research and identify effective strategies to deal with the issue.

MDHFS completed and released the report, Sexually Transmitted Diseases in Minneapolis: Incidence Rates and Preventive Strategies at a press conference on April 16, 1998. The press conference was held at Pilot City Health Center and numerous representatives were invited and attended, including those from the African American Health Care Workers Group, Urban League, Urban Coalition, The City, Inc., Minneapolis Public Schools, community clinics, and Indian Health Board. Peer high school educators from Minneapolis Public Schools spoke at the news conference.

A community forum was announced at the press conference to discuss findings and look at generating cooperative community initiatives to address the problem. Two community forums were held in late April and early June with representation from many of the same groups as the news conference.

At the second meeting the larger group decided to break down into two task forces to more effectively address the issues. The Public Education Workgroup decided to work on education issues with the Minneapolis Public Schools. The Public Awareness Group decided to work on a media campaign.

The Public Awareness Task Force contracted with staff from the Minnesota Family Planning and STD Hotline at Family Tree Clinic to conduct a media campaign from November, 1998 - February, 1999 consisting of bus shelter ads and posters, as well as television and radio public service announcements featuring popular music producer, Jimmy Jam. A comparison of calls to the Hotline during the same time frame the previous year before the campaign (November, 1997 - February, 1998) and during the campaign found a 12% increase in total calls. However, there was a 65% increase from radio-generated calls and a 97% increase from TV-generated calls.

The Public Education Task Force planned, presented, and evaluated a daylong workshop, "STIs: New Name, Same Game" December, 1998 for Minneapolis Public School health teachers and school nurses. The workshop featured staff from community agencies, such as Teen Age Medical Service, Planned Parenthood, the

Annex, YWCA, and others. The peer educators from Southwest and North High Schools made a presentation, and the acting troupe from Pillsbury Neighborhood Services gave a presentation on the topic. The evaluations were very positive, a tribute to the eleven different agencies who cooperated to make it happen. There has been a request from the Minneapolis Public Schools to repeat this workshop during the 1999-2000 school year.

SENIORS

The City of Minneapolis' Senior Citizen Ombudsman program became part of the MDHFS in 1997. There was a realization that senior health and social issues previously had not been priorities in either City or past health department activities. The first step in remedying this gap was to commission a research report through Wilder Foundation on contributions, resources, and needs of seniors in Minneapolis. New information was provided by Minneapolis seniors who took part in focus groups and by a new key informant survey that was conducted for the report. Many organizations and people took part in guiding the research, gathering relevant data, recruiting focus group participants and participating as key informants. A complete list is available in the report, Older Adults in Minneapolis: Contributions, Resources and Needs. A sample includes Eldercare, Council on Black Aging, HCFA Healthy Seniors Program, Minneapolis Age and Opportunity Center, MN Elders Coalition, and Senior Resources.

Also, SHAPE data was being collected to assess the general health of the adult population of Minneapolis and suburban Hennepin County. The report, The Health of Minneapolis Seniors, was released in May, 1998 and provided for the first time ever, comprehensive health status information about seniors at the City level.

The MDHFS initially planned one community forum to release the reports. However, the forum generated great interest in the senior community and took on a life of its own. In the end, two forums were held to discuss the reports and a third was held to identify needs and determine next steps. It was out of these meetings that the group recommended establishing a multi-jurisdictional Senior Coordinating Board to determine policies on seniors at the city and county governmental level.

A resolution was brought to the Minneapolis City Council, and in May, 1998 the Council passed a resolution to establish a Task Force for the purpose of making a recommendation on the feasibility of establishing a multi-jurisdictional Senior Coordinating Board. The Task Force consisted of representatives from the City wards, agencies serving seniors, senior representatives, and the existing Minneapolis Senior Citizens Advisory Council.

The Task Force gathered information from three primary sources. First, local reports were generated by the MDHFS and the United Way on Minneapolis seniors. The two MDHFS reports were, The Health of Minneapolis Seniors: A Report from the SHAPE Project, May, 1998 and Older Adults in Minneapolis: Contributions, Resources, and Needs, December, 1997. Second, Task Force members interviewed over 45 individuals knowledgeable about older adults and their concerns. Third, the Task Force scheduled presentations with officials, including Former Mayor Donald Fraser

on the structure of the current Minneapolis Youth Coordinating Board as a possible model for the Senior Coordinating Board. Members also interviewed by telephone representatives of senior coordinating and planning boards in North Carolina.

The Task Force reached almost unanimous agreement in recommending the establishment of a Senior Coordinating Board to the Minneapolis City Council. On October 26,1998, the Minneapolis City Council passed a resolution directing MDHFS to research the legal and logistical issues of establishing a multi-jurisdictional Senior Coordinating Board.

V. Priority Setting Process 2000-2003

Public health problems for the City of Minneapolis were summarized and prioritized with contributions from the Minneapolis Public Health Advisory Committee (PHAC), MDHFS staff, and the MDHFS management team (consisting of division directors and the Commissioner). This process occurred through winter and early spring and was essentially completed in two phases.

First, a consultant listed public health problem areas based on the following criteria: information coming out of the department's research activities (which includes substantial community input as discussed in the needs assessment process section); priorities identified by the PHAC; included on those public health areas in which MDHFS is involved; and, only for those issues for which local assessment data is available. This resulted in 39 problems being identified under 16 of the 18 state public health goals.

In the second phase, the results were synthesized and revised by the management team. The PHAC then discussed and approved the final priorities for the CHS plan. Staff were instructed to rank the problems in two ways. First, is the problem of high, medium, or low importance for the residents of Minneapolis? Second, is the problem of high, medium, or low importance/appropriateness for MDHFS? An example where these two might differ is food borne illness. This problem is of high importance for Minneapolis but falls under the purview of the City's Regulatory Services Department, giving it a low ranking for appropriateness for MDHFS.

See the attached document of the draft problem statements, provided to staff for prioritizing. The results of the prioritizing process are indicated on the document. Those problem statements determined to be high priorities are highlighted in red, medium priorities are highlighted in blue, and low priorities are not highlighted. The ten high and seven medium priority problems were included in the CHS plan.

Below are listed additional problem statements and public health areas of concern identified in the priority process for which there is not readily available data. These are important areas and most are included in the program plan as a future work objectives. These areas are:

1. Less than half of American Indian, African American, and Hispanic youth in Minneapolis graduate from high school, increasing their risk for poverty and its accompanying social and health problems.
2. There is a need to identify and take action on concrete linkages between health status and social problems as poverty, employment, housing, and education.
3. Child abuse and neglect.
4. Types and extent of violence in Minneapolis (e.g. fights, assaults, suicide, and homicide).
5. How poverty affects the lack of and quality of housing and nutrition.
6. Poverty and the elderly.
7. Police and EMS capability to respond to domestic abuse calls.
8. Frail elderly in Minneapolis.

9. Workplace issues such as violence, mental illness, ergonomics.
10. Healthcare access and quality of health care systems for children.
11. Impact of illicit drugs.
12. As welfare and health subsidies end for those making the transition off public assistance, what happens to their health?
13. What is the relationship between pregnancy, single motherhood, and being enrolled on welfare?
14. What groups have higher social health status despite high social risks? What fosters positive development?

Two staff decision-making groups reviewed the prioritization. One was the Strategic Initiatives (long range planning) group, which includes the Commissioner of Health, some managers, and some staff working on strategic directions for MDHFS. The second group was the management team. The following priorities have also been reviewed with and approved by the Mayor and Council.

With all this input, MDHFS priorities were developed. These priorities are:

1. Three major long term initiatives:
   - attaining and maintaining family stability and self-sufficiency for all Minneapolis citizens;
   - health and welfare of new arrivals to this country; and,
   - domestic violence.
2. Eight other short and long term significant initiatives, which are discussed in the plan:
   - health care access and system delivery;
   - chemical abuse and prevention;
   - seniors;
   - housing, including lead;
   - asthma;
   - school health data
   - CHAMP; and,
   - improved contract management systems.

The final priority problems and draft CHS plan was presented to the PHAC at their June meeting, and was approved. These priorities will direct the work of the MDHFS, and became the priority problems the plan addresses.

MINNEAPOLIS DEPARTMENT OF HEALTH FAMILY SUPPORT
COMMUNITY HEALTH SERVICES PLAN
DRAFT PROBLEM STATEMENTS FOR 2000-2003

PROBLEM STATEMENTS	Results: High – red highlights Medium – blue highlights **Low – not highlighted**	PROBLEM IMPORTANCE (H,M,L)	AGENCY MDHFS IMPORTANCE (H,M,L)
Goal 1: Reduce the behavioral risks that are primary contributors to morbidity and mortality.			
1. Alcohol abuse among Minneapolis youth and adults is a serious public health problem, leading to injury, assault, accidental death, and homicide.			
2. Tobacco use impacts all age groups through disease and disability, high rates of smoking among young adults, and children's exposure to second hand smoke in the home.			
3. Significant percentages of adults in Minneapolis are overweight, sedentary, smoke, and engage in risky drinking patterns, increasing their risk for premature morbidity and mortality.			
Goal 2: Improve birth outcomes and early childhood development			
4. Minneapolis compares less favorably than the State of Minnesota on major birth indicators, including teen pregnancy and births, unmarried mothers, and women who did not receive adequate prenatal care.			
5. Infant mortality rate in Minneapolis is higher than the Year 2000 goals, especially for women of color. This is due to complex factors, including inadequate prenatal care, fragmentation of women's health care, not identifying pregnancy risk factors, and lack of provider cultural competence.			
Goal 3: Reduce unintended pregnancies			
6. Although national studies found teenage pregnancy rates declined 8% from 1991 to 1995, the Minneapolis teenage pregnancy rate has remained constant. The percentage of births to women under 20 has also remained constant at 14.5%.			
7. Families are at risk for economic and emotional stress due to unintended pregnancy.			
Goal 4: Promote health for all children, adolescents and their families.			
8. Adolescents are at high risk for a constellation of health concerns, including STDs, unintended pregnancy, accidents, alcohol and tobacco abuse, suicide, and homicide.			

Goal 5: Promote, protect, and improve mental health.		
9. There is a need for early detection and effective interventions to improve the mental well-being of children and youth.		
10. Suicide rates for Minnesota youth from populations of color are some of the highest in the nation.		
11. Of the 20% of adults who suffer from an active mental disorder in any given year, only 10-21% receive treatment because of delayed recognition, cost, and stigma of mental illness.		
Goal 6: Promote a violence-free society.		
12. Homicide is the leading cause of death for Minneapolis youth and young adults between the ages 15 and 24. A high proportions of those victims (ages 12-22) are victims of gun violence.		
13. Minnesota data reflects an over-representation of certain populations in individual categories of violence, including rates of homicide in children under one, African American males aged 15-44, American Indian males aged 25-44, as well as the rates of maltreatment of children with disabilities and of African American children.		
Goal 7: Reduce the behavioral and environmental health risks that are primary contributors to unintentional injury.		
14. Unintentional injury is the single greatest killer of Minnesotans between ages one and 34 with motor vehicle-related injuries the leading cause of death. The populations with the highest risk for motor vehicle-related injury include young (ages 15-24) drivers, male drivers, drivers over 80 years old, bicyclists, and motor cyclists not wearing helmets. The rate of motor- vehicle-related death is highest among American Indians.		
15. The leading cause of unintentional injury deaths in the home among seniors 65 and older is falls.		
16. Children are at high risk of being injured, through suffocation, poisoning, fire, drowning, and playground injuries.		
Goal 8: Improve the outcome of medical emergencies.		
NONE		
Goal 9: Reduce infectious disease		
17. There are high rates of STDs in Minneapolis, particularly among women, adolescents, communities of color, and particular geographic communities. African American women are at greatest risk.		
18. Young children are not being fully immunized against vaccine-preventable disease.		
19. HIV-related deaths continue to be the number one cause of death for adults 22-44 years of age.		

Goal 10: Promote the well being of the elderly, those with disability, disease and/or chronic illness.		
20. There is a lack of a continuum of coordinated services to meet the needs of seniors to maintain an independent and healthy lifestyle.		
21. There is a lack of a continuum of coordinated services to meet the needs of those with disabilities, disease, and/or chronic disease.		
Goal 11: Reduce exposure to environment health hazards.		
22. There is a continued risk for foodborne illness due to improper handling or preparation, as well as a changing food supply.		
23. Individuals are may become ill due to indoor pollutants and risks such as lead based paint, molds, secondhand smoke, carbon monoxide, and emissions from building materials.		
24. There is a risk of contamination of the environment due to improper management of solid waste and toxic/hazardous waste.		
Goal 12: Promote early detection and improved management of noninfectious disease and chronic conditions.		
25. African American women and men over 45 have the highest death rates due to cancer.		
26. Almost half of Minneapolis seniors (49.3%) report they have arthritis/rheumatism, causing pain, disability, and loss of independence.		
27. Asthma is a serious chronic condition, affecting significant numbers of school children, as well as Minneapolis adult residents.		
Goal 13: Promote optimal oral health for all Minnesotans.		
28. Over one-third of Minneapolis residents postpone dental work due lack of insurance and cost.		
Goal 14: Reduce work-related injury and illness.		
NONE		
Goal 15: Assure access to and improve the quality of health services.		
29. Over 20% of Minneapolis residents are without medical insurance sometime during a year.		
30. School children's needs in such areas as immunizations, communicable diseases, chronic health problems, social and emotional health and special health needs, require innovative partnerships with schools, public health and the private health care system.		
31. Many health issues such as alcohol and tobacco abuse, chronic diseases, and behavioral change require effective collaboration among public, private, and non-profit organizations		

Goal 16: Ensure an effective local and state government public health system.		
32. Develop more effective, ongoing work relationships with community stakeholders when developing, implementing, monitoring, and evaluating public health initiatives and programs.		
Goal 17: Eliminate the disparities in health outcomes and the health profile of populations of color.		
33. Health disparities exist in the African American community in the areas such as homicide, infant mortality, adequate prenatal care, STDs, and cancer deaths.		
34. Health disparities exist in the American Indian community in areas such as infant mortality, adequate prenatal care, accidental injury, suicide, and alcohol-related problems.		
35. African Americans and American Indians have higher death rates than the white population ages 15-45.		
36. American Indians have the highest rate of heart disease among all population groups.		
37. Populations of color are less likely than whites to have private or public insurance.		
Goal 18: Foster the understanding and promotion of social conditions that support health.		
38. Lower income residents tend to have worse physical and mental health than higher income adult residents, with the exception that residents living just above the poverty line have worse physical and mental health than those living at or below poverty do.		
39. Poverty among children in Minneapolis increases their risk for developmental delays, physical and mental health problems, and intentional and unintentional injury.		

VI. COMMUNITY HEALTH SERVICES PROGRAM PLANS: 2000-2003

FAMILY PLANNING, PRENATAL CARE, BIRTH OUTCOMES, AND CHILDREN 0-5 YEARS OLD

I. Problem Statement(s)
- A. Minneapolis compares less favorably to the state of Minnesota on major birth indicators such as teen pregnancy and births, births to unmarried women, and women who did not receive adequate prenatal care.
- B. Infant mortality in Minneapolis is higher than the Year 2000 goal, especially for American Indian and African American women. This is due to complex factors including inadequate prenatal care, fragmentation of women's health care, not identifying pregnancy risk factors, and lack of provider cultural competence.
- C. Preschool children are not being fully immunized against vaccine-preventable diseases.
- D. Families are at risk for economic and emotional stress due to unintended pregnancy.

II. Healthy Minnesotan 2004 Goals
- A. (2) Improve birth outcomes and early childhood development.
- B. (3) Reduce unintended pregnancy.
- C. (9) Reduce infectious disease.

III. Healthy Minnesotan 2004 Objectives
- A. (2.1) Reduce to no more than 5.0 per 1000 live births the infant mortality rate.
- B. (9.5) Ensure that at least 90 percent of infants in all geographic areas, racial and ethnic groups, and socio-economic strata will receive age-appropriate immunizations against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, Hib disease, and hepatitis B; and at least 60 percent receive immunizations for varicella within two months of the recommended age as measured by population-based surveys.
- C. (3.1) Reduce the proportion of all pregnancies that are unintended.

IV. Program Plan:
- A. Child Health Assessment and Monitoring Project (CHAMP)
  This is a major initiative for the MDHFS.
  1. Objectives
     - a. By 2001, conduct a survey of the health of Minneapolis children aged 6-24 months, analyze data, and create recommendations for population health improvements. Preliminary findings will be produced by March, 2000. Subsequent findings/reports will be published during the balance of 2000 through 2002.
     - b. Depending on study findings, develop recommendations and action plans for improvements in children's health with public and private decisionmakers by 2001.

2. Method
    a. Conduct a survey of parents with children aged 6-24 months about their children's health, parent involvement, day care, assets of the parents and community, the child's learning environment, housing, income, and use of government and community services by early 2000.

V. Ongoing Activities
- A. Immunizations: MDHFS will promote immunization of preschool children through:
    1. Participating in the development of the metropolitan-wide Immunization Registry which combines a contract with Hennepin County's registry (Immulink) and public and private providers in the seven county Metro Area for the purpose of tracking immunizations.
    2. Cooperating with and providing funding to Neighborhood Health Care Network to promote immunizations.
- B. Family Planning: Continue providing Maternal and Child Health Special Project funding to community clinics to address reproductive health, pregnancy testing, family planning, counseling and supplies. Continue working with MDH on a statewide work group to address family planning funding for the next two years.
- C. Prenatal care and birth outcomes: Continue activities to implement Project LID (Lower Infant Deaths) recommendations for enhancing the survival of infants (See LID report). Continue providing Maternal and Child Health Special Project funding to community clinics for prenatal care. Seek additional grants to fund initiatives for prenatal care for underserved populations. Because populations in poverty are at increased risk for infant mortality, MDHFS will address this through our major initiative in attaining and sustaining self-sufficiency.
- D. Ongoing research activities: MDHFS Research Unit will continue to collect, analyze, and report vital statistics and other information on the health of Minneapolis residents.
- E. Ongoing policy activities
    1. MDHFS will join with other stakeholders in advocating for expanding the Basic Sliding Fee Child Care program.
    2. Support increased availability of noncompetitive statewide funding to provide a continuum of community-based prevention and early intervention activities that promote healthy birth outcomes, optimal child health, and prevent maltreatment.

VI. Contracts, Grants, Administrative Agreements
- A. Metro Immunization Registry
- B. Hennepin County Community Health Department
- C. Children's Dental Services
- D. Way to Grow
- E. Neighborhood Health Care Network
- F. Headstart

G. 348-TOTS through Hennepin County Community Health Department
H. Greater Minneapolis Council of Churches, Division of Indian Works
I. Greater Minneapolis Day Care Association
J. Metropolitan Visiting Nurses Association
K. Maternal and Child Health Special Program (MCHSP) competitive contracts in 1998-99:
    1. Uptown Community Clinic
    2. Family Medical Center
    3. Southside Community Clinic
    4. Fremont Community Clinic
    5. Community University Health Care Clinic (CUHCC)
    6. Planned Parenthood
    7. Minnesota Indian Women's Resource Center
    8. Indian Health Board
    9. Glenwood Lyndale Community Center
    10. Cedar Riverside People's Center

VII. Community Resources
A. Many of the organizations working on these health issues are represented in the list of contracts. Since MDHFS provides very little direct service, our links to these agencies is through funding. Also, we have worked together on joint projects, involved these agencies in any initiatives around birth outcomes and children's health, and provided consultation and training. Other agencies we work with in this content area are St. Paul/Ramsey County Public Health Department, Bloomington Health Department, and the Minnesota SIDS Center.

VIII. MDH Assistance
A. Continue to receive MDH support and consultation for infant mortality projects, including funds for infant mortality policy and implementation activities.
B. Complete state led initiative to set policies and standards to minimize infant mortality.
C. Leadership and funding from MDH for Metro Area and statewide immunization registries.

IX. MDHFS Program Contact: Janet Howard, (612) 673-3735

SCHOOL-AGE CHILDREN AND YOUTH

I. Problem Statement(s)
   A. Although national studies have found that teenage pregnancy rates declined 8% from 1991 to 1995, the Minneapolis teenage pregnancy rate has remained constant. Also, the percentage of births to women under 20 has remained constant at 14.5%.
   B. Adolescents are at high risk for a constellation of health concerns including STDs, unintended pregnancy, accidents, alcohol and tobacco abuse, suicide, and homicide.
   C. There are high rates of STDs in Minneapolis, particularly among women, adolescents, communities of color, and particular geographic communities. African American women are at greatest risk.
   D. Asthma is a serious chronic condition, affecting significant numbers of school children, as well as Minneapolis adult residents.
   E. School children's needs in such areas as immunizations, communicable diseases, chronic health problems, social and emotional health, and special health needs will not improve without innovative partnerships among the school system, public health agencies, and the private healthcare system.

II. Healthy Minnesotan 2004 Goals
   A. (3) Reduce unintended pregnancies.
   B. (4) Promote health for all children, adolescents, and their families.
   C. (9) Reduce infectious disease.

III. Healthy Minnesotan 2004 Objectives
   A. (1.1 & 1.3) Decrease the percentage of adolescents who smoke cigarettes and/or use spit tobacco.
   B. (1.7) Reduce from 37 to 30 percent the proportion of high school seniors who have used alcohol at least once a month for the past 12 months. Reduce from 20 to14 percent the proportion of ninth-grade students who have used alcohol at least once a month for the past 12 months.
   C. (3.4) Reduce adolescent pregnancy rates as follows: from 27.5 pregnancies per 1000 women aged 15-17 (1996) to no more than 26.9 per 1000 women aged 15-17; and from 77.3 pregnancies per 1000 women aged 18-19 (1996) to no more than 76.7 per 1000 women aged 18-19.
   D. (3.6) Increase from 44 to 50 percent the proportion of sexually active sixth graders who always use birth control. Increase from 59 to 64 percent the proportion of sexually active twelfth graders who always use birth control.
   E. (4.14) Promote positive adolescent development through increasing (by 25 percent from 1995 levels) the percentage of high school students who talk to their parents about problems they are having; state positive feelings about school; state that they have received most of their information about sex from their parents, school, teachers or

counselors; state school personnel care about them; and state their parents care about them.

F. (4.20) Increase the number of school-based and school-linked health clinics providing primary care and mental health services for adolescents.

G. (12.13) Reduce asthma morbidity (as measured by a reduction in asthma hospitalization).

H. (12.15) Begin collecting Minneapolis-specific (originally, Minnesota-specific) data on asthma incidence, prevalence, and severity.

I. Reduce from 52 cases per 100,000 people to no more than 40 cases per 100,000 people the overall incidence of gonorrhea.

J. (4.26) Reduce from 145 to no more than 100 cases per 100,000 people the overall prevalence of chlamydia infection.

III. Program Plan:

A. School Health Data

This is a major initiative for MDHFS.

1. Objectives
   a. Cooperate with the Minneapolis Public Schools and other community stakeholders to determine the best way to develop a surveillance system for student health data by 2003.
   b. As a first step, identify gaps and barriers to implementing the most effective system for developing a student health surveillance system by 2001.
2. Methods
   a. Assess the current data collection system maintained by the Minneapolis Public Schools Health Related Services program.
   b. Assess the health and human service stakeholders' interest and capacity to collect school-age health data.

B. Asthma Management

This a major initiative for MDHFS.

1. Objectives
   a. Assist the Minneapolis Public Schools in developing and implementing a comprehensive asthma management initiative by 2003 in cooperation with the American Lung Association and the Healthy Learners Board.
   b. Assist the Healthy Learners Board to develop policies for schools, medical providers, and communities for coordinated management of asthma.
2. Methods
   a. Cooperate with the School Health Data project in collecting and analyzing data on students with asthma.
   b. Establish a Systems Management Committee composed of representatives from the Minneapolis Public Schools, American Lung Association, Healthy Learners Board, medical providers, and community members to meet and set comprehensive asthma management policies.

C. Social and Emotional Health

This is a major initiative for MDHFS.

1. Objectives
   a. Assist the Minneapolis Public Schools, in cooperation with the Healthy Learners Board, in developing and implementing a comprehensive initiative by 2003 to address the significant social and emotional health needs of students.
   b. Strengthen the capacity of the School Based Clinic Program to meet the current overwhelming social and emotional needs of students served by the program.
2. Methods
   a. Assess the current data collection system to determine capacity to collect data related to social and emotional needs.
   b. Increase social service staff in School Based Clinics from 2.5 FTE to 4.0 FTE social workers.

V. Ongoing Activities

A. School-Based Clinics (SBC): MDHFS will continue to operate school-based clinics in five high schools and four alternative sites to provide sports physicals, immunizations, pregnancy and STD testing, family planning exams and prescriptions. Staff will continue to assist students in getting medical homes outside SBCs. A large part of SBC work is dealing with social and emotional problems of students. Individual and group counseling and referrals are provided by clinic staff, which includes 2.5 full time social workers. SBC staff continues to collect data for patient care and composite data for community and policy makers. Also, staff management continues to assess and develop sound ways to finance student health services.

B. Youth access to alcohol and tobacco: Continue to work with the Minneapolis Police Department to institutionalize compliance checks on beverage alcohol retailers. Provide representation to the Hennepin County Community Prevention Coalition and the University of Minnesota Alcohol, Tobacco, and other Drugs Task Force to support and enhance their youth prevention efforts in Minneapolis.

C. School age immunizations: Continue to work with Metro Immunization Registry. Cooperate with Minneapolis Public Schools' "No Shots, No School" campaign, the Welcome Center, and the Metro Immunization Registry general initiatives through Health Related Services to promote immunizations. Immunizations will be given through the School Based Clinics as appropriate.

D. Ongoing research activities: Continue to monitor teen pregnancy rates, STD rates, and other behavioral risk factors drawn from vital statistics in Minneapolis. Support the enhancement of the School Clinic data collection system, as well as development of Minneapolis Public School's data collection system. Report key findings to policy makers and program administrators.

E. Ongoing policy activities
   1. Continue to support policy and legislative initiatives that enhance the health of adolescents in such areas as medical services, STDs, alcohol, tobacco, family planning, and teen parents.
   2. Work with stakeholders to ensure that minor consent continues for reproductive health care, chemical dependency counseling, and some mental health services.

VI. Contracts, Grants, Administrative Agreements
   A. Minneapolis Public Schools
      1. Health Related Services: Maternal and Child Health Special Projects
      2. School Health Redesign Services
      3. Welcome Center
      4. School-Based Clinic related contracts:
         a. Plymouth Christian Youth Center
         b. Teenage Medical Services
         c. Kathie Amble, Consultant
         d. Jill Leverone, Psychologist
         e. Pilot City Health Center
         f. Hennepin County Nutrition Services/WIC
         g. Incompass
         h. Hennepin Faculty Associates
   B. Charles Good, Evaluator
   C. Metropolitan Health Plan
   D. Children's Dental Services
   E. Joanne Mooney, Consultant
   F. Minneapolis Youth Diversion: Project Offstreets
   G. Youth Coordinating Board/ Phat Summer, City of Minneapolis
   H. Minneapolis Urban League/Curfew Truancy
      I. Youth Employment and Training
      2. American Indian OIC
      3. Employment Action Center-Youth MFIP & Youth Hired
      4. Loring-Nicollet-Bethlehem Community Center
      5. Jump Start
      6. Minneapolis Urban League
      7. Pillsbury Neighborhood Services
      8. Youth Trust

VII. Community Resources: Many of the organizations working on these health issues are represented in the list of contracts. MDHFS still provides direct services through the school based clinics, but many of our links to these agencies is through funding. Also, we have worked together on joint projects, involved these agencies in any initiatives around school age children and youth, and provided consultation and training. These agencies will be invited to work with MDHFS in developing the major new initiatives in this area.

VIII. MDH Assistance

A. Technical assistance from the Center for Health Statistics on surveillance data for school age populations.

B. There is a need for more comprehensive state-generated data on children's asthma and mental health problems.

IX. MDHFS Program Contact: Gretchen Musicant, (612) 673-3955

COMMUNITY HEALTH

I. Problem Statement(s)
   A. Homicide is the leading cause of death for Minneapolis youth and young adults between the ages of 15 and 24. A high proportion of those victims (aged 12-22) are victims of gun violence.
   B. Minnesota data reflects an over-representation of certain populations in individual categories of violence, including rates of homicide for children under one, African American males aged 15-44, American Indian males aged 25-44, as well as the rates of maltreatment of children with disabilities and of African American children.
   C. Family violence, composed of child maltreatment, as well as domestic and intimate partner violence, is by far the most prevalent form of violence in Minnesota.
   D. There are high rates of STDs in Minneapolis, particularly among women, adolescents, communities of color, and particular geographic communities. African American women are at greatest risk.
   E. There is a lack of a continuum of coordinated services to meet the needs of seniors to maintain an independent and healthy lifestyle.

II. Healthy Minnesotan 2004 Goals
   A. (6) Promote a violence-free society.
   B. (9) Reduce infectious disease.
   C. (10) Promote the well being of the elderly, those with disability, disease and /or chronic illness.
   D. (11) Reduce exposure to environmental health hazards.

III. Healthy Minnesotan 2004 Objectives
   A. (6.3) Reduce by 15 percent child maltreatment in Minnesota.
   B. (6.4) Reduce by 15 percent domestic and intimate partner violence in Minnesota.
   C. (6.6) Reduce by 15 percent youth violence in Minnesota.
   D. (9.17) Ensure that by the year 2004, at least 90 percent of newly arrived refugees in Minnesota receive a domestic refugee health assessment.
   E. (10.1) Increase years of healthy life (as measured by quality-adjusted life years) by two years.
   F. (10.2) Increase the number of communities that offer elderly persons a full continuum of care.

IV. Program Plan:
   A. <u>Health and welfare of new arrivals</u>
      This is one of MDHFS' top three priorities.
      1. Objectives
         a. Assess needs, and create recommendations and policies to guide development of effective programs at MDHFS and the City of Minneapolis to meet the needs of new arrivals.

b. Determine changes needed for the City of Minneapolis to develop procedures that meet the needs of those with limited English-speaking abilities.
c. In cooperation with other stakeholders, develop Minnesota standards for certification of medical language interpreters.

2. Methods
a. Sponsor a collaborative with internal and external stakeholders to assess current activities and service gaps, as well as develop recommendations and policies.
b. Research current literature and key service providers on definitions of immigrants, differences in services based on definitions, existing regulations, current services, strategies, and resources.
c. Collaborate with Minneapolis Public Schools, Hennepin County, and others with the Welcome Center to provide an early connection with limited English-speaking families to help them access services.
d. Work with Interpreter Standards Task Force to develop standards for medical interpretation certification.

B. Domestic Abuse

This is one of MDHFS' top three priorities.

1. Objectives
a. Develop consistent and effective policies and coordination among City Departments, as well as the County and other community organizations working with domestic abuse.
b. Assure a strong working relationship between the Police Department and MDHFS in working on domestic abuse issues.

2. Methods
a. Sponsor a collaborative with internal and external stakeholders to assess current activities and service gaps, as well as develop recommendations and policies.
b. Assess the cost and extent of domestic abuse, as well as the relationship between child maltreatment and domestic abuse.
c. Meet with Police Department to strengthen working relationship.

C. Seniors

This is a major initiative for MDHFS.

1. Program objectives
a. By 2001, establish a multi-jurisdictional Senior Coordinating Board comprised of elected officials from the City of Minneapolis, Hennepin County, and the State of Minnesota to advocate for visionary public policy and programs that help older adults maintain a high quality of life in Minneapolis.

b. Restructure the City of Minneapolis' Senior Advisory Council from its current configuration to a 23 member Committee with Minneapolis senior citizens from each of the 13 wards and ten representatives from organizations that provide services to older adults. This Senior Advisory Committee will act as a community resource and recommend policy issues for the Senior Coordinating Board to address.

2. Methods
   a. Provide staff support for the development of the Senior Coordinating Board, including researching legal, political, and social issues. Determine need for legislative action to form the joint powers board and develop a budget and a formula for contributions by each of the participants.
   b. Determine the ongoing role of MDHFS with the Senior Coordinating Board, particularly in regards to the activities of the Senior Citizen Ombudsman Program.
   c. The Senior Advisory Committee will continue to enhance communication among service providers and inform older adults and their families about available services.

D. Housing & Health Initiative

This is a major initiative of MDHFS.

1. Program objectives
   a. Develop initiative that addresses the concrete relationship between housing and family health and well being.
   b. After research, adopt policy initiatives that will inform and advocate for housing that promotes family health and well being.
2. Methods
   a. Review and summarize existing studies and data sources that identify concrete linkages between housing and family health and well being, with particular attention to the issues of lead and asthma.
   b. Include housing and health data in coordinating the Child Health Assessment and Monitoring Project (CHAMP).

E. Chemical Misuse Program

This is a major MDHFS initiative.

1. Objectives
   a. Develop appropriate and effective public health response to drug problems in the City of Minneapolis.
   b. Bring group of internal and external stakeholders together to study research findings and develop recommendations for a citywide public health response to drug use issues.
2. Methods
   a. Research existing sources of data such as the Substance Abuse Monitoring System (SAMS), the Minnesota Student Survey (MSS), and METP client data for current drug use patterns in Minneapolis.

b. Create a methamphetamine users survey, administer survey, and analyze data.

VI. Ongoing Programs

A. Housing Services: This program provides information to landlords and tenants in the City of Minneapolis about rental rights and housing issues. Housing advocates counsel clients on residential rental issues, provide education on rental rights, act as an information and referral service on housing issues, and help tenants and landlords prepare for housing and conciliation court.

B. Survey of the Health of Adults, the Population, and the Environment (SHAPE): MDHFS will continue to analyze data, write and disseminate reports on health behavior of Minneapolis residents to community stakeholders, policy-makers, health program planners, and the public. MDHFS will be consulting with community stakeholders on the feasibility of conducting a second SHAPE survey and comparing those results with the original SHAPE findings.

C. The "Stay Alive" program was developed in 1998 after Minneapolis-based research highlighted the need for youth violence prevention. Research identified that 60 percent of arrestees and suspects were 14-24 years of age. The Stay Alive program developed league basketball for 17-25 year-old African American and American Indian males during the summer months in three high-risk neighborhoods of Minneapolis. The program is coordinated by MDHFS, Ghetto Basketball League (GBL), Harriet Tubman Center, and Twin Cities Healthy Nations. The program will continue to offer organized basketball and community cookouts, as well as education about jobs, training, life enhancement skills, rites of manhood, and cultural history.

D. Senior Ombudsman Services will continue to provide consultation, information and assistance to City senior citizens. The program provides information, tax assistance, home visits, and a written guide to senior services.

E. The American Indian Advocacy program will continue to create and maintain an open channel of communication between the Minneapolis American Indian community and the City of Minneapolis. The goal is to make City services more relevant and accessible, and to increase understanding by City officials and staff of issues in the Indian community. Also, the program will continue to serve as a liaison between the Indian community and City Hall by answering questions, resolving problems, and directing American Indians to the appropriate City department for assistance.

F. Environmental health: Although the Environmental Health program is not organizationally part of MDHFS, staff continue to cooperate on health issues. The Environmental Health Division of the City's Regulatory Services, protects the public from foodborne illness by enforcing Minneapolis, state, and federal laws through inspections, licensing, investigations, education, and certification of food workers. The Division began using the Hazard Analysis Critical Control Points inspections in 1997. The Lead Abatement Program continues to identify

contaminated housing and affected children, and remedy the situation through referrals and abatement activities.

G. Ongoing policy activity: Oppose legislation that would increase the availability and prevalence of handguns in Minneapolis.

VII. Contracts

A. Neighborhood Health Care Network (Immulink and 489-CARE line)
B. Minnesota Aids Project
C. Minneapolis Youth Diversion Project
D. Hennepin County Community Health Department: Disease Prevention and Control and Immulink
E. Cindy Kallstrom, Health Education Consultant
F. Metropolitan Visiting Nurses Association
G. Domestic Abuse Project
H. Harriet Tubman Center
I. Little Earth of United Tribes
J. Elaine Stately Peacemaker Center
K. Minneapolis Age and Opportunity Center
L. Legal Aid Society
M. Southeast Seniors: A Living at Home Block Nurse Program

VIII. Community Contacts

Many of the organizations working on these health issues are represented in the list of contracts. MDHFS does not provide direct services in this area, so many of our links to these agencies are through funding. Also, we have worked together on joint projects, involved these agencies in any initiatives around community health, and provided consultation and training. These agencies will be invited to participate in developing our major new initiatives in community. Hopefully, many of them will participate in developing these programs.

IX. MDH assistance

A. Conduct and/or research outcome-based studies on violence prevention.
B. Provide data on quality-adjusted life years by county and major cities such as Minneapolis.
C. Continued research on effective legal tools for changing drug and alcohol use norms, i.e. compliance checks.

X. MDHFS Contact: Patty Bowler, (612) 673-3009

SOCIAL HEALTH, DISPARITIES, AND ACCESS TO SERVICES

I. Problem Statement(s)
   - A. Over 20% of Minneapolis residents are without medical insurance sometime during the year.
   - B. Health disparities exist in the African American community in such areas as homicide, infant mortality, adequate prenatal care, STDs, and cancer deaths.
   - C. Health disparities exist in the American Indian community in areas such as homicide, infant mortality, adequate prenatal care, STDs, and cancer deaths.
   - D. Populations of color are less likely than whites to have private or public insurance.
   - E. Lower income residents tend to have worse physical and mental health than higher income adult residents do.
   - F. Poverty among children in Minneapolis increases their risk for developmental delays, physical and mental health problems, and intentional and unintentional injury.

II. Healthy Minnesotan 2004 Goals
   - A. (15) Assure access to and improve the quality of health services
   - B. (17) Eliminate the disparities in health outcomes and the health profile of populations of color.
   - C. (18) Foster the understanding and promotion of social conditions that support health.

III. Healthy Minnesotan 2004 Objectives
   - A. (15.1) Achieve 100 % health care coverage, including preventive services, for all Minnesotans.
   - B. (15.4) Increase to 100% the percentage of Minnesota's population that has a regular source of care.
   - C. (15.5) Increase the cultural competency of all health care professionals within the health care delivery system to ensure that culturally appropriate, quality care is available to all Minnesotans.
   - D. (15.6) Decrease the number of Minnesotans who forgo needed health care services because of transportation or distance problems.
   - E. (15.7) Develop mechanisms and systems to aid consumers' understanding and practical ability to utilize health care delivery systems appropriately within Minnesota.
   - F. (17.25) Strengthen the capacity of the health care system to improve the health status of populations of color.
   - G. (18.1) Review and summarize existing studies and data sources that identify concrete linkages between social conditions and health.
   - H. (18.4) Discuss the impact of social conditions that contribute to poor health in terms of their organization's sphere of influence.
   - I. (18.5) Collaborate with community efforts to improve social conditions that affect health.

IV. Program Plan:

A. Individual and family stability and self-sufficiency

This is one of three top priority initiatives for MDHFS.

1. Objectives
   a. Develop and implement policies and programs that increase and maintain individual and family stability and self-sufficiency in the City of Minneapolis.
   b. Integrate MDHFS activities in the areas of public health, employment and training, and human services to move toward more coordinated services and referrals among health, employment, and other agencies.
   c. Working with welfare and employment services, monitor what happens to health and social status after welfare recipients reach their limit of benefits.
2. Methods
   a. Research specific conditions and services that promote individual and family stability and self-sufficiency, including private conditions and resources, as well as public programs and policies.
   b. Produce a report using SHAPE data examining health status and individual and community income levels.

B. Health care access and system delivery

One of MDHFS' major initiatives.

1. Objectives
   a. By 2002 finish a health access needs assessment, develop and implement a health care access strategy, and evaluate activities. Analyze populations experiencing difficulty with health care access, as well as system difficulties in providing access.
   b. Develop a Health Care Access Community Collaborative to develop and implement a health care access strategic plan.
   c. Depending upon assessment's findings and recommendations, advocate for improvements in policy and programmatic activities that will improve health care access.
2. Methods
   a. A full-time CDC Prevention Specialist assigned to MDHFS for two years will provide leadership for the project.
   b. Prevention Specialist will organize and staff a Health Care Access Community Collaborative to help accomplish the needs assessment, as well as develop a policy and programmatic project plan based on the findings of the assessment. Representation will be from such groups as the Minneapolis Public Schools, Hennepin County, MDH, MDHS, the Neighborhood Health Care Network, the Minnesota Legislature, and other community health agencies.

c. Prevention Specialist and Collaborative will write an implementation plan that defines actions steps and organizational responsibilities for members of the collaborative and other community stakeholders.

d. Though final content of the plan would depend upon assessment's findings and recommendations of the Collaborative, the plan could include such activities as:
   1) Incorporating collaborative recommendations into the programmatic functions of various stakeholders,
   2) Designing and conducting public information campaigns targeting consumers,
   3) Advocating for improving health care access through presentations of the assessment's findings and recommendations to various groups, such as the Minneapolis City Council, Minnesota Council of Health Plans, State Departments of Health and Human Service, and private health systems and insurers,
   4) Identifying and supporting legislative proposals that further the Collaborative's recommendations.

e. The Commissioner of Health and Family Support will chair a statewide committee on uncompensated care.

f. Collaborate with Children's Defense Fund to pilot access activities at the Minneapolis Public School's Welcome Center.

V. Ongoing Activities

A. Minneapolis Employment and Training Program (METP)

1. The goal of METP is to assist disadvantaged and dislocated adults and youths in preparing to enter private sector employment. METP will continue to manage state, federal, and locally funded employment and training services via contracts with private and nonprofit organizations, as well as provide direct services. METP will continue to work with programs for youth, dislocated workers, Minnesota Family Investment Program clients, older employees, and disadvantaged adults. Services provided include job readiness assessment, training, counseling, placement, and work-based learning. METP has a rigorous evaluation system that measures job placement success, as well as compliance and success of contract agencies.

B. Ongoing research activities

1. METP does surveillance of the labor market situation and trends in the Metro Area.

C. Ongoing policy activities

1. At the Legislature, advocate for continuance and strong funding for MNCare, as well as simplification of the program (especially the program forms).
2. Monitor PMAP enrollees in Minneapolis to ensure they are getting medical and support services they need.

3. Advocate for a strong safety net for uninsured and underinsured residents in Minneapolis, including the continued financial viability of the community clinics.

VI. Contracts, Grants, and Administrative Agreements

A. Employment and Training:

1. Catholic Charities
2. Center for Asians & Pacific Islanders
3. Episcopal Community Services
4. Eastside Neighborhood Services
5. Exodus Community Development Corporation
6. Employment Action Center
7. Early Childhood Resource Center
8. Hennepin County WERC
9. Freeport West
10. Hired
11. Powderhorn/Phillips Wellness Center
12. Hmong American Partnership
13. Indian Chamber of Commerce
14. Jewish Vocational Services
15. Pillsbury Neighborhood Services
16. Loring Nicollet Bethlehem Services
17. Catholic Charities
18. Minneapolis Public Housing Authority
19. Person to Person
20. Minneapolis Urban League
21. Minnesota Department of Economic Security
22. University of Minnesota Extension
23. Pillsbury Neighborhood Services
24. Urban Hope Ministries
25. Project For Pride in Living
26. American Indian OIC
27. Southeast Asian Refugee Community Home
28. Anishinabe Council of Job Developers
29. Minnesota Department of Economic Security – Dislocated Worker Program
30. Phillips Community Development Corporation
31. Resident Management Corporation.
32. Employment Action Center: Dislocated Worker Program
33. Southeast Asian Refugee Community Home
34. Employment Action Center
35. Summit Academy OIC
36. Twin Cities Rise
37. Women Venture
38. Hmong American Mutual Assistance Association
39. Loring- Nicollet- Bethlehem Community Center

B. Access to Health Services contracts
    1. Neighborhood Health Care Network and individual clinics
    2. Children's Dental Services
    3. Metropolitan Visiting Nurses Association

VII. Community Resources
A. Many of the organizations working on these health issues are represented in the list of contracts. MDHFS does not provide direct service in this area, so many of our links to these agencies are through funding. Also, we have worked together on joint projects, involved these agencies in community health initiatives, and provided consultation and training. These agencies will be invited to participate in developing our major new initiatives in health access. Hopefully, many of them will participate in developing these programs.
B. Additional agencies we will work with include:
    1. Hennepin County Community Health Department
    2. Hennepin County Economic Assistance
    3. Minneapolis Public Schools
    4. Minnesota Department of Health
    5. Minnesota Department of Human Services
    6. Minnesota health plans
    7. Minnesota State Legislature
    8. Neighborhood Health Care Network
    9. St. Mary's Clinics
    10. Children's Defense Fund

VIII. MDH Assistance
A. Active participation on our health care access collaborative.
B. Minnesota Department of Health, Department of Human Services (DHS), and community partners research and monitor relationship between health and welfare status, particularly finding out what happens when recipients finish eligibility for welfare benefits.
C. In cooperation with DHS, evaluate Medical Assistance financing and reimbursement levels, as well as simplification of Minnesota Care application forms.

IX. MDHFS Program Contact: Becky McIntosh, (612) 673-2884

INSTITUTIONAL WORKING RELATIONSHIPS

I. Problem Statement(s)
   A. Develop more effective ongoing work relationships with community stakeholders when developing, implementing, monitoring, and evaluating public health initiatives and programs.

II. Healthy Minnesotan 2004 Goal
   A. (16) Ensure an effective local and state government public health system.

III. Healthy Minnesotan 2004 Objectives
   A. (16.6) MDH and MDHFS, in partnership with health care research institutions, higher education institutions, and others, will identify priority public health surveillance, information, research, and evaluation needs, and will develop plans to address them.
   B. (16.9) MDH and MDHFS information systems will provide a means to collect information about indicators to assess their performance of essential public health services.
   C. (16.14) MDH and MDHFS will have, or participate in the development of, a response plan for disease outbreaks and natural and human-made disasters

IV. Program Plan:
   A. Public Health Initiatives
      An MDHFS major initiative.
      1. Objective
         a. Significantly increase the capacity of MDHFS to undertake priority public health initiatives outlined in this plan, and to respond to emerging public health needs in a timely manner in coordination with key stakeholders
      2. Method
         a. By early 2000, have staff in place with primary responsibilities for leading initiatives.

   B. Contract Administration
      An MDHFS major initiative.
      1. Objectives
         a. Create an integrated, comprehensive contract system focused on outcomes and performance measures by 2001.
         b. Ensure all contracts between MDHFS and service contractees are developed in accordance with relevant laws and regulations, and in compliance with multiple funding sources.
         c. Ensure contracts are processed in a timely manner so that 90% are fully executed prior to contract start date in 2000 and 95% in 2001.

d. Ensure administrative expenses are less than 10% of available contract funds.

2. Methods
   a. Develop and implement a performance management effectiveness system.
   b. Develop improved performance measures, particularly for the largest contracts.
   c. An annual contract monitoring site visit will be made for at least 50% of health contracts by 2001.
   d. Contract managers will conduct quarterly compliance reviews using upgraded monitoring tools.
   e. By early 2000, evaluate the effectiveness of the largest contracts, and make any recommendations for changes in allocations to the City Council.

V. Ongoing Programs
   A. Public Health Laboratory: MDHFS Public Health Laboratory provides clinical, environmental, and drug testing for City departments, Hennepin County, State agencies, the public, and law enforcement agencies throughout the Metropolitan Area.
   B. Ongoing policy activities: Research and advocate for more secure funding for community-based health services such as community clinics and school based clinics. Continue to collaborate with other community stakeholders in the private and public sector to develop more effective programs, funding, and policy initiatives to address the health care needs of the citizens of Minneapolis.
   C. Participate in on-going discussions with other public and private health entities to plan and execute emergency procedures for disease outbreaks, as well as other natural and human-made disasters.

VII. Contracts, Grants, and Administrative Agreements
   A. Hennepin County Medical Center (for direction as needed)
   B. Accustaff
   C. Mary Hourigan, Consultant
   E. Minnesota Department of Health (for lab consultation)
   F. Renee Wixon, Consultant
   G. Parenteau Graves Communications, marketing and public relations consultants

VIII. Community Resources

First, in creating a better system to monitor and evaluate contracts, all 150 entities we have contracts with are potential resources. The groups have been listed throughout the CHS plan under the appropriate program areas. The second major group of resources are all the other local, county, state, and federal entities we work with in carrying out our public health responsibilities. Finally, as we carry out new and emerging public health initiatives, we have multiple relationships with community stakeholders. Many of these are contractees and others are other groups mentioned throughout the Plan.

IX. MDH Assistance

A. Simplify the grant funding processes for local health departments, and provide additional funds for public health initiatives.

B. Increased input by local health departments into MDH decisions and planning.

X. MDHFS Program Contact: Becky McIntosh, (612) 673-2884

VII. Evaluation of CHS Plan 2000 – 2003

Evaluation of both process and outcomes of a project are critical, yet difficult. Process evaluation can help determine program resources needed to carry out a program, while outcome evaluation helps us know which interventions really work. The Minneapolis Department of Health and Family Support is vitally interested in doing both process and outcome evaluations for our programs and initiatives.

Many MDHFS programs are provided through contracts granted to community organizations to carry out program goals and objectives. In fact, MDHFS has over 150 contracts in contrast to two direct service programs, the School-Based Clinics and the Public Health Laboratory. Contracted programs present different evaluation challenges than direct service programs. When program objectives are carried out by another agency, gathering process information and outcome data can be difficult.

Contract management evaluation

One of the major initiatives described in the section of the plan, "Institutional Relationships," discussed MDHFS' intention to develop a contract management system based on outcomes and performance measures. MDHFS will develop the capacity to gather better process data, as well as outcome data. The first priority is to start with the largest contracts. Based on those program objectives, MDHFS will evaluate:

1. Creation of integrated and comprehensive contract system focused on outcomes and performance measures by 2001.
2. Development of enhanced performance measures for the largest contracts for contract year 2001.
3. Processing of contracts in a timely manner, so that 90% are fully executed prior to contract start date in 2000, and 95% in 2001.
4. Conducting monitoring site visits for at least 50% of contracts by 2001.
5. Conducting quarterly compliance reviews by contract managers using upgraded monitoring tools by 2000.

School-age smoking cessation evaluation

The Minneapolis Department of Health and Family Support conducts in-school smoking cessation programs for adolescents in three Minneapolis public high schools and one middle school. The curriculum takes between eight to eleven sessions and focuses on teaching skills to quit smoking and to remain smoke free.

Past evaluations have found that of all participants, 40% attended at least half of the sessions. Historically, attrition rates with teen tobacco cessation programs have been so high as to render them essentially useless. The attendance rate is considered very good in the world of teen smoking cessation programs. The program also found that 17% of students had quit by the end of the program, and that 73% had decreased the amount they were smoking. This quit rate is higher than for adult cessation programs.

The program will continue with evaluation of attendance, as well as whether students increase, decrease, or quit smoking.

Stay Alive

The Stay Alive Project is a basketball program for male youth and young adults of African American or American Indian heritage. The program is designed to help prevent violence by providing a life-skills curriculum for these young men. The program began in the summer of 1998 and an evaluation was conducted after it ended. Enrollment levels were high, and an evaluation showed that the participants were successfully recruited from the priority population (as indicated by the majority of participants being the target ages, race/ethnic backgrounds, and many (56%) having criminal histories). An evaluation of the project for 1999 is in progress.

Future evaluations will focus on:

1. Does the program continue to attract young males at risk for violent crimes?
2. What are the retention rates of the program, and what program components engage the priority population?
3. Do participants commit fewer crimes during and after the program?
4. Can the project be successfully expanded into the Asian and Latino communities?

Future evaluations

MDHFS has identified three major priorities for the future -- self-sufficiency, domestic violence, and new arrivals. All three of these initiatives are in the beginning stages of planning as of mid-1999. The Department received a new Commissioner of Health and Family Support, David Doth, in March, 1999. With a new Commissioner comes a reassessment of the Department's work, as well as strategic thinking for the future. This has coincided with the CHS planning process.

Plans are in the very preliminary stages for these initiatives and specific program goals and objectives are not yet defined. Until more detail is developed on these initiatives, it's not possible to write specific evaluation plans. However, MDHFS is committed to evaluating these initiatives and will develop evaluation strategies as part of the project plans. We will report on evaluations for these initiatives by the next two-year update.

Other programs will continue to collect process information, and where appropriate, carry out more extensive evaluations alone or with community partners.